**MARYLAND HEALTH CARE COMMISSION**

***UPDATE OF ACTIVITIES***

**May 2008**

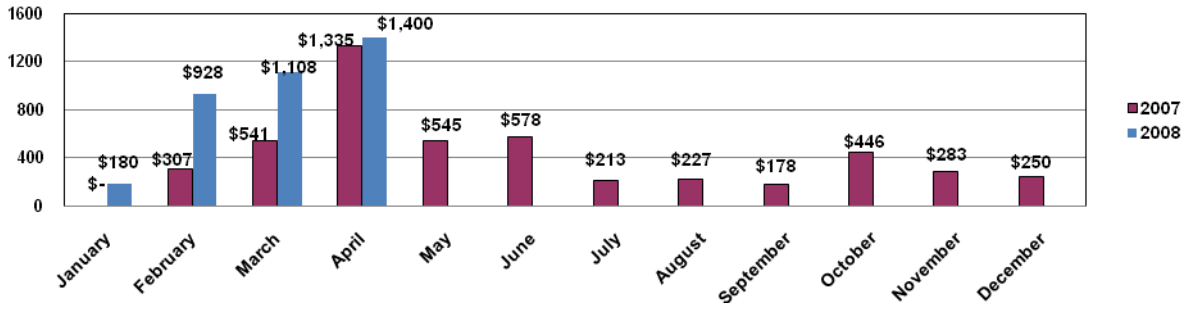
***CENTER FOR INFORMATION SYSTEMS AND ANALYSIS***

## *Maryland Trauma Physician Services Fund*

### Uncompensated Care Processing

CoreSource Inc., the third party administrator (TPA) for the Trauma Fund, adjudicated claims with a total paid value of approximately $1.4 million in April. The monthly payments for uncompensated care over the past fifteen months are shown in Figure 1. Over the last 3 months the Fund has reimbursed physicians almost $3.4 million compared to about $2.2 million for a similar period in 2007.

Figure 1 -- Uncompensated Care Payments FY 2007 and 2008
(in 000s)




### Trauma Equipment Grants

Trauma Centers must disburse all funds from the 2007 equipment grants no later than June 30, 2008 and send an itemized disbursement report to the Commission directly thereafter. All hospitals must submit a report.

### Trauma Uncompensated Care Reimbursement

Staff is automating the submission of check requests to the General Accounting Department. Slow payment has been one complaint of practices that are participating in the Trauma Fund.

### SB 916 – Maryland Trauma Physician Services Fund – Reimbursement and Grants

Governor Martin O'Malley signed the bill into law on April 24th. The Commission is required to implement the new law effective July 2008. Staff presented a summary of the new law's requirements to TraumaNet (Maryland's trauma community) in April. In addition, staff is drafting proposed changes to COMAR 10.25.10 in consultation with staff members from the Maryland Institute for Emergency Medical Services Systems (MIEMSS), the Health Services Cost Review Commission (HSCRC), and the members of TraumaNet.

## ***Data and Software Development***

**Medical Care Data Base**

Staff released the 2007 Medical Care Data Base (MCDB) submission manual to insurance companies and HMOs (payers) that submit claim and encounter information to the MHCC. Under Commission regulation at COMAR 10.25.06, twenty-six payers have been identified as collecting more than $1 million in health insurance premiums, and therefore, are required to submit this data. The 2007 MCDB submission includes several new reporting requirements. In the medical care claim data, the Delivery System Type category has been expanded to include Exclusive Provider Organizations (EPOs). The Pharmacy Data File has been expanded to include a new field for the Prescription Claim Number. Finally, the Provider Directory File has been expanded to include three new required fields: the National Provider Identifier (NPI) number, the Maryland Health Professional License number, and the Maryland Health Professional Board Code.

Data from the MCDB supports analyses for several annual reports, including State Health Care Expenditures, Practitioner Utilization and Expenditures, and Prescription Drug Use and Expenditures. The data base also provides information used in more focused Commission-published "Spotlights" on specific areas of interest to policymakers. The data submission is due by July 1, 2008.

**Web Development for Internal Applications**

Work continued in April on six MHCC web applications. The top priority was the development of the premium subsidy application, however important work was also completed on the EDI Assessment and the Physician pricing application. The following sites are newly operational or underdevelopment**.**

**Table 1– MHCC Web Applications Under Development**

| Board | Anticipated Start Development/Renewal | Launch date |
|---|---|---|
| **Premium Subsidy Program** | **Underway** | **September 15th** |
| MHCC Assessment | On-line | Complete |
| EDI Assessment | Under Development | 06/1/08 |
| LTC Survey | Modifications Underway | 08/01/08 |
| Physician Pricing | Complete | |
| ADA Compliant NH Guide ADA Compliant with ADA Guidelines | Not Started | Under determined |
| Redesign of Hospital Guide | External Contractor | Not Specified |

**Health Occupation Boards License Renewals**

Staff continued to make progress on license renewal applications for the occupation boards. Table 2 presents the status on development for health occupation boards.

**Table 2– Health Occupation Boards with Web Applications Under Development**

| Board | Anticipated Start Development/Renewal | Start of Next Renewal Cycle |
|---|---|---|
| Occupational Therapy | On-line | Underway |
| Audiologists | On-line | Underway |
| Acupuncture | On-line | Underway |
| Morticians | On-line | Complete |
| Dietetic | Not started | 08/11/08 |
| Dental | Underway, | Underway |
| Physician | Not Started | 07/15/08 |
| Chiropractic | Not started | 09/01/08 |
| Optometry | Not started | 06/30/09 |

## ***Cost and Quality Analysis***

The staff will release ***Practitioner Utilization: Trends Among Privately Insured Patients, 2005-2006*** this month. The report, mandated under MHCC's enabling statute, examines payments to physicians and other health care practitioners for care provided to privately insured Maryland residents under age 65. This year's report includes an executive summary and three chapters. The first chapter is an introduction which describes the Commission's mandate for the report and summarizes the data and methods used in the analysis. It includes definitions for key terms and any caveats that affect interpretation of estimates produced for the report.

Chapter 2 presents an overview of fee-for-service spending on practitioner services covered by private insurance in 2006. Among all insured users of practitioner services, the average per-user expenditure for practitioner services was $941, equivalent to about 2 percent of per capita income in Maryland in 2006. This is 4 percent higher than per-user spending in 2005. The distribution of users between HMO and non-HMO products was similar to 2005, with about 60 percent of users enrolled in non-HMO plans. The share of users enrolled in consumer-directed health plans (CDHP) continued to grow, doubling to 2 percent of all users. The two largest payers in Maryland's private insurance market covered more than 70 percent of these nonelderly users. Additional information in this chapter describes how annual per-user spending and utilization varied by: region of the state, type of coverage (individual plan, small group market, public employer, private employer), type of plan (HMO versus non-HMO), and market share (largest payers versus other payers). There is also a figure that illustrates the trend in inflation-adjusted spending for practitioner services, on a per user basis, from 2002 to 2006, and information on the percent of spending for practitioner services that was paid out-of-pocket.

Chapter 3 analyzes the relationship between price, volume, intensity, and total spending among users who were enrolled in a private insurance plan for the entire year, which includes three-fourths of all users. Spending on practitioner services among full-year enrollees averaged $1,046 in 2006, up 3 percent from 2005. Spending per user is highly dependent on a user's health status, ranging from an average of $381 per user among those with a low risk of needing services to an average of $ 1,998 per user among the high risk group. The mix of low-, medium-, and high-risk users varies considerably by coverage type but not by plan type. CDHPs and non-CDHP individual plans have higher shares of users that are of low-risk, which makes their average per-user expenditure lower than among other plans. However, the average

spending per low-risk user is actually highest in CDHP plans. Compared to the largest payers, other payers averaged higher per-user spending in each risk category due to their higher reimbursement rates. Other information in this chapter describes how patient risk is distributed by coverage type, plan type, and insurer market share, and how private payer reimbursement compares to what the spending per user would have been under the Maryland Medicare fee schedule.

Usually the Practitioner Report includes a chapter dedicated to a current policy topic; this year, however, we will release the policy-related analysis in a separate issue brief to allow for greater analytical detail and discussion. The issue brief will focus on the underlying causes for the significantly lower earnings among primary care physicians compared to other physician specialties, a topic of concern for the Governor's Task Force on Health Care Access & Reimbursement.

**Task Force on Health Care Access and Reimbursement**
The meeting on April 29th focused on physician supply issues. Stakeholders agreed that primary care and emergency medicine physicians face shortages in many parts of the state. Those deficits are likely to increase in the future. Shortages are acute in rural areas, especially those areas of the state that are being transformed from rural to urban. Data provided by the Office of Primary Care also showed that populations in older urban areas also face access problems due to lack of insurance coverage or low income. The Task Force will consider the following options in the final report:

(1) Expand existing loan assistance repayment program (LARP) with state-only funding. The current program provides for loan repayment for physicians that practice in health provider shortage areas (HPSAs). The federal government matches the state contribution under the current program. Increasing federal contributions are unlikely;
(2) Provide incentives through rate setting for rural and urban hospitals with poor supply/access to offer loan forgiveness for residents who practice in their areas; and
(3) Expand collection of data on physician supply from the Maryland Board of Physicians/MHCC.

## *CENTERS FOR HEALTH CARE FINANCING AND LONG-TERM CARE AND COMMUNITY BASED SERVICES*

### ***Small Group Market***

**Comprehensive Standard Health Benefit Plan (CSHBP)**
At the February public meeting, the Commission approved final regulations on the incorporation of an Exclusive Provider Organization (EPO) as an additional plan type to be offered in the small group market. The regulations were implemented effective March 24, 2008 and carriers can begin selling this new product on July 1, 2008.
Each year, participating carriers in the small group market are required to submit completed survey forms that include enrollment and premium information in the CSHBP. This year's analysis is based on data for the calendar year ending December 31, 2007. For comparative purposes, it also includes enrollment by age and geographic location of the business for both CY 2006 and CY 2007. Later in today's meeting, Commission staff will present the findings of these surveys.

**Small Employer Health Benefit Plan Premium Subsidy Program**

At the February public meeting, the Commission adopted both emergency regulations (for an immediate effective date) and proposed permanent regulations that specify the components of wellness benefits offered under small employer health benefit plans. These regulations are required under SB 6, the *"Working Families and Small Business Health Coverage Act,"* enacted during the Special Session of November 2007. The regulations were submitted to the Department of Business and Economic Development (DBED) and the Administrative, Executive, and Legislative Review Committee (AELR) for approval. The emergency regulations were approved on April 1, 2008 and will expire on August 18, 2008. The proposed permanent regulations were published in the Maryland Register on April 11, 2008. The public comment period ends on May 12, 2008. Staff will present these regulations to the Commission for approval at the June public meeting.

Commission staff is in the process of drafting regulations to implement the Premium Subsidy Program, also required under SB 6. This new Program will be available to certain small employers with 2 to 9 eligible employees as long as they meet the requirements outlined in the law and meet certain salary, wage and other requirements established by the Commission through regulation. Staff held an informational meeting on the draft regulations on May 1st. Later in today's meeting, Commission staff will present the draft regulations to the Commission for approval as both emergency and proposed permanent regulations.

**Limited Benefit Plan**
As required under Chapter 287 of the Acts of 2004 and Chapter 627 of the Acts of 2007, the Commission was required to develop a report for the General Assembly on the overall enrollment in the Limited Benefit Plan since its inception on July 1, 2005 through June 30, 2007. The report also included alternative options for individuals enrolled in the Limited Benefit Plan. At the December 2007 public meeting, the Commission approved the report and copies of the report were submitted to the General Assembly. The report also is posted on the Commission's website. The requirement that prominent carriers offer the Limited Benefit Plan in the small group market will sunset on June 30, 2008.

## ***Health Plan Quality and Performance***

**2008 Performance Evaluation: HEDIS Audit and CAHPS Survey**

**HEDIS Audit**
Staff continued to monitor completion of the key functions from the HEDIS audits conducted by the contractor, HealthcareData.com (HDC). In addition, staff attended the onsite audit evaluations of Kaiser Permanente, United Healthcare, and CareFirst BlueCross BlueShield. Oversight at this level provides staff with the opportunity to directly engage with the audit team and key representatives consisting of contracted audit staff, plan representatives, and plans' delegated/outsourced business entities.
Progress with PPO quality measurement has remained on schedule. As with any new undertaking, many lessons emerged though implementation of the process. Staff had a series of conference calls with plan representatives and audit staff to resolve issues related to the eligible population undergoing review for the PPO products. With slightly more than a month remaining before the audit concludes, staff put together an initial set of process improvement measures in preparation for the next cycle.

**Consumer Assessment of Health Plan Study (CAHPS Survey)**
The final phase of the CAHPS survey of plan members, telephone administration to non-respondents, began at the end of April and will continue throughout most of May. At the conclusion of the phone phase, the survey contractor will prepare the data to determine final rates of response.
The survey contractor has received instructions for final due dates and data submissions to various organizations. Staff will provide specific instructions on the content and analysis required for final

reports. Reports will be submitted to the individual plans, MHCC, OPM, and NCQA. CAHPS results will be presented, along with clinical data, in the 2008/2009 health plan performance publications.

**Report Development Contract--Procurement**
A request for proposals (RFP) for Health Plan Report Development work for the next contract period (2008 - 2012) was submitted to and approved by the Department of Budget and management. The evaluation committee that reviewed proposals scored as most favorable to the state the proposal from the National Committee for Quality Assurance (NCQA). The committee recommended that the contract for development of health plan performance reports be awarded to NCQA.

MHCC staff will attend the May 21st meeting of the Maryland Board of Public Works. That body will take final action on the contract for report development for the contract period 2008 - 2009, which provides for an extension period of three one-year intervals through May 31, 2012.

## ***Racial and Ethnic Disparities***

Staff successfully arranged and coordinated a meeting with key representatives of the National Business Group on Health. The National Business Group on Health and the DHHS Office of Minority Health recently "launched a broad-based Racial/Ethnic Disparities Initiative to address the impact of racial and ethnic health disparities on employee health and productivity. The first step of this initiative was the creation of the Racial/Ethnic Disparities Advisory Board which will link employers with medical professionals, researchers, and racial and ethnic disparities experts in order to share information, ideas, and developments in their fields and to oversee initiative activities." As a result of the meeting, Bruce Kozlowski has been asked to serve on the Advisory Board (a list of current members is attached), Ben Steffen will serve on a Data Subcommittee, Rod Taylor will serve on a Employer Survey Subcommittee and Dr. David Mann, the epidemiologist for the DHMH Office of Minority Health and Tobacco Restitution Fund will serve on a Communications Subcommittee.

In response to a written request from Delegate Nathan-Pulliam, staff has created a Racial and Ethnic Disparities Work Group. The Work Group which is comprised of health plan, state agency, university and other stakeholder representatives (see attached list of invitees) is tasked with addressing collection and reporting of Maryland specific race and ethnicity data, to share initiatives stakeholders may have underway, and to use these data to collaboratively assess and address health and health care disparities in Maryland. This will be a multi-year effort that supports a "thoughtful approach that recognizes the diversity of plans and implementation challenges."

Staff recently met with the Executive Directors recently appointed by the Governor to head two special population commissions: (1) the Maryland Commission on Hispanic Affairs and (2) the Maryland Commission on Indian Affairs. Both directors expressed an interest in working with both the Maryland Health Care Commission and the Maryland Office of Minority Health to obtain data and information that will assist them in educating their members and constituents as well as advising the Governor.

## ***Long Term Care Policy and Planning***

**Hospice Data**
The Fiscal Year 2007 Maryland Hospice Survey was released for online survey completion effective March 5, 2008. Staff has been monitoring survey completion by means of weekly conference calls with OCS, the contractor for the survey. Staff has also sent follow-up emails to hospice programs reminding them of due dates for survey completion. To date, 25 of the 30 hospice programs have completed Part I of the survey. Part II, which contains financial data from their cost reports is due in June. A matrix has been developed by OCS the survey contractor to log the status of all hospice surveys. Issues with survey

completion are discussed in weekly calls with OCS and suggestions offered for survey improvements in the next survey cycle.

**Home Health/Residential Service Agencies**
Staff is providing support to the programmers in the process of creating the statistical tables/analysis for FY 2007 home health agency data. This will be used later to support planning and certificate of need activities.

Commission staff also reviewed the proposed new Regulations .01 - .28 under COMAR 10.07.05 Residential Service Agencies, and submitted comments to the Department of Health and Mental Hygiene (DHMH). Standards and requirements for licensure as a Residential Service Agency (RSA), as well as clarification of the nursing oversight for certain RSA clients requiring companion and other non-health related services are described in these proposed regulations. These regulations describe the initial and renewal licensure processes and requirements, as well. Ongoing monitoring and inspection by DHMH of RSAs is an important component of these regulations; specifically, with regard to the appropriate training and supervision of individuals providing care to the clients in their homes.

**Long Term Care Survey**
Staff is in the process of preparing for the 2007 Maryland Long Term Care Survey scheduled for release in July 2008. Tasks include: updating the survey application, testing the application, verifying/compiling inventory and recreating the reporting system.

**Other**
Long Term Care Staff will attend the annual Lifespan Conference "Passport to Excellence in Senior Care Services." This conference will be held in Ocean City, Maryland May 5-8. Topics include: best practices, market research, baby boomer preferences, culture change, use of technology, Medicaid reimbursement, staffing, hospice, home care, and others.

## ***Long Term Care Quality Initiative***

**Long Term Care Web Site Enhancement**
A meeting was held with LTC industry representatives and interested partners from the Maryland AARP to develop details of the web enhancement. Staff is in the process of writing specifications for the scope of work and identifying web sites with desired format and content.
"Fine tuning" of the Nursing Home and Assisted Living Guides takes place on a continuous basis. Links to other useful sites is an ongoing effort as is the search for ways to increase ease of navigation for users of the Guides.

**Family Survey**

1) Staff updated the work plan for the coming year and has exercised another option year with the outside vendor with the procurement scheduled to go before the Board of Public Works for approval in late May.
2) A meeting was held with long term care stakeholders to discuss proposed changes to the survey instrument. This is being done collaboratively with the two nursing home associations and the LTC Advisory Group which is comprised of a diverse group of stakeholders.

Work continues on design and content for the next update of the Nursing Home web site. The intent is to modify the site so that it provides a greater focus on community-based alternatives and support services to support independent living with transition to Assisted Living, CCRCs, and Nursing Homes.

## *CENTER FOR HOSPITAL SERVICES*

### ***Hospital Services Policy and Planning***

### ***Certificate of Need (CON)***

**CONs Issued**
The Green House at Stadium Place (Baltimore City) – Docket No. 07-24-2224
Construction of a new comprehensive care facility ("CCF") with 49 beds to be located at 1100 East 33rd Street in Baltimore
Cost: $12,406,446

**Pre-Licensure/First Use Approval Issued (Completion of CON-Approved Projects)**
Stella Maris (Baltimore County) – Docket No. 04-03-2145
Renovations and upgrade to a currently delicensed 42-bed comprehensive care unit at the facility
Cost: $7,373,000

Johns Hopkins Hospital (Baltimore City) – Docket No. 03-24-2119
Renovations to the exterior of the Billings, Wilmer, Marburg and Phipps Buildings, rehabilitation of the stream generating plant; replacement of 2 electrical chillers and replacement of emergency electric engine generators
Cost: $25,649,233

**CON Letters of Intent**
Franklin Square Hospital (Baltimore County)
Introduce adolescent psychiatric services at the hospital

**CON Applications Filed**
Levindale Hebrew Geriatric Center and Hospital (Baltimore City) – Matter No. 08-24-2247
Renovations to the current building and construction of a new 3-story patient tower adjacent to the existing facility, adding 38 comprehensive care beds
Cost: $32,148,178

St. Mary's Hospital (St. Mary's County) – Matter No. 08-18-2248
Expansion and renovation, including the addition of 26 medical/surgical/gynecologic/ addictions beds, 2 psychiatric beds, 2 operating rooms, and 23 emergency department bays. The project also includes construction of shell space, relocation of support services and construction of a hospital annex
Cost: $80,841,804

**Pre-Application Conference**
April 24, 2008
Franklin Square Hospital (Baltimore County)
Introduce adolescent psychiatric services

**Application Review Conferences**
April 16, 2008

St. Mary's Hospital (St. Mary Co) – Matter No. 08-18-2248
Expansion and renovation, including the addition of 26 medical/surgical/gynecologic/ addictions beds, 2 psychiatric beds, 2 operating rooms, and 23 emergency department bays. The project also includes construction of shell space, relocation of support services and construction of a hospital annex
Cost: $80,841,804

April 18, 2008
Levindale Hebrew Geriatric Center and Hospital (Baltimore City) – Matter No. 08-24-2247
Renovations to the current building and construction of a new 3-story patient tower adjacent to the existing facility, adding 38 comprehensive care beds
Cost: $32,148,178

**Determinations of Coverage**

**Acquisitions**
Forestville Health & Rehabilitation Center (Prince George's County)
South River Health & Rehabilitation Center (Anne Arundel County)
Marley Neck Health & Rehabilitation Center (Anne Arundel County)
Fort Washington Health & Rehabilitation Center (Prince George's County)
Fayette Health & Rehabilitation Center (Baltimore City)
Ellicott City Health & Rehabilitation Center (Howard County)
Bel Pre Health & Rehabilitation Center (Montgomery County)
Liberty Heights Health & Rehabilitation Center (Baltimore City)
Acquisition of these 8 facilities by OMG RE Holding, LLC, a wholly-owned subsidiary of HC Real Estate Holdings, LLC, which is a member of the family of companies that do business as CommuniCare Health Services.

Haven Nursing Home (Baltimore City)
Sale of 25% of the stock of the facility, control of the facility will not change

**Capital Threshold**
Annapolis Nursing & Rehabilitation Center (Anne Arundel County)
Capital project at the facility adding 1) multi-purpose space for residents; 2) kitchen space; 3) elevator access to the basement; and 4) space for future expansion
$1,139,120
DETERMINED NOT TO REQUIRE REVIEW

Northampton Manor (Frederick County)
Capital project for new construction and renovation of the facility
$9,372,068
DETERMINED TO REQUIRE REVIEW

**Delicensure of Bed Capacity or a Health Care Facility**
Bethesda Health & Rehabilitation Center (Montgomery County)
Temporary delicensure of 30 CCF beds

Greater Laurel Health & Rehabilitation Center (Prince George's County)
Temporary delicensure of 17 CCF beds

**Relicensure of Bed Capacity or a Health Care Facility**
Bel Pre Health & Rehabilitation Center (Montgomery County)
Relicensure of 10 temporarily delicensed CCF beds

**Relinquishment of Bed Capacity**
Transitional Care Unit at St. Joseph Medical Center (Baltimore County
Relinquishment of 32 temporarily delicensed CCF beds

**Other**
Maryland Masonic Homes (Baltimore County)
Conversion of the secure dementia unit back to a general health care unit
$500
DETERMINED NOT TO REQUIRE REVIEW

**Ambulatory Surgery Centers**
College Park Surgery Center (Prince George's County)
Establish an ambulatory surgery center with 2 non-sterile procedure rooms to be located at 4611 Assembly Drive, Suite K, Lanham

Box Hill Surgery Center (Harford County)
Establish an ambulatory surgery center with 1 non-sterile procedure room to be located at 100 Walter Ward Boulevard, Suite B2, Abingdon

Hendi Ambulatory Surgery Center (Montgomery County)
Establish an ambulatory surgery center with 5 non-sterile procedure rooms to be located at 5454 Wisconsin Avenue, Suite 725, Chevy Chase

**Waiver Beds**
Shady Grove Nursing & Rehabilitation Center (Montgomery County)
Addition of 10 comprehensive care waiver beds to facility

## ***Policy and Planning***

A draft State Health Plan Chapter for Acute Hospital Care Services, COMAR 10.24.10, proposed as a replacement for the existing SHP Chapter for Acute Inpatient Services was posted on the MHCC web site on May 6, 2008 for informal review and comment.. An Acute Care Planning Work Group assisted Commission staff in developing this draft Chapter during 2007. Hospitals and other persons interested in acute hospital services were notified that this material is now available for informal review and comment. It includes standards to be used in the review of Certificate of Need projects proposed by acute care general hospitals and also includes updated need projections for MSGA and pediatric beds. The informal review and comment period will run through June 6, 2008.

## ***Hospital Quality Initiatives***

The Hospital Performance Evaluation Guide Advisory Committee held its monthly meeting on April 28th to discuss various activities associated with the maintenance and expansion of the Hospital Performance Evaluation Guide (HPEG). During the meeting, staff provided an update on the recently released Hospital Consumer Assessment of Healthcare Providers & Systems (HCAHPS) survey results. The 27 item survey focuses on patients' perspectives and ratings on such topic areas as communication with physicians and nurses, the hospital environment, pain control, communication on medication use, and discharge information. The staff presented an analysis of the performance of individual hospitals as well

as a comparison with other states and nation as a whole. Finally, the staff summarized procurement activities surrounding the establishment of a Quality Measures Data Center to support the Maryland Hospital Performance Evaluation System.

In support of MHCC's hospital quality initiatives, staff continues to reach out to other units within DHMH, federal agencies, professional organizations and other states, to share and gather information and to identify opportunities for collaboration and improvement. These activities are highlighted below:

- *National Healthcare Safety Network (NHSN)*

The Division of Healthcare Quality Promotion of the CDC manages the National Healthcare Safety Network (NHSN), an internet-based surveillance system that integrates patient and healthcare personnel safety surveillance systems. In accordance with the recommendations of the HAI Technical Advisory Committee, the NHSN system will be the vehicle for collecting data on certain health-care associated infection data and quality measures from Maryland hospitals. Maryland hospitals are required to use the NHSN system to report data to the Commission on Central Line-Associated Blood Stream Infections in any intensive care unit, beginning July 1, 2008.

On April 25th, MHCC in partnership with the Maryland Hospital Association and the Greater Baltimore and Washington D.C. Metro Chapters of the Association for Professionals in Infection Control and Epidemiology, sponsored a Statewide NHSN Training Seminar for hospitals. The seminar was well attended with over 100 hospital representatives covering all 47 hospitals participating in the event. Staff will continue to provide training and guidance to hospitals on NHSN enrollment and system requirements to facilitate hospital compliance with the technical specifications of the surveillance system and the data reporting requirements of the MHCC.

CHS staff continues to participate in the NHSN State Users monthly teleconferences to stay abreast of issues surrounding HAI hospital performance measures and to share experiences with representatives from other states.

## ***Specialized Services Policy and Planning***

On April 17, 2008, the Commission approved the primary percutaneous coronary intervention (pPCI) waiver application filed by Carroll Hospital Center (Docket No. 08-06-0026 WN). Beginning June 17, 2008, the hospital must file bimonthly reports regarding its progress in implementing pPCI services.

The Commission published an updated schedule for receipt of pPCI waiver applications in the *Maryland Register* on May 9, 2008. The updated schedule is also available at: http://mhcc.maryland.gov/hospital_services/specialservices/cardiovascular/pci/regnotice050908.pdf.

On April 23, 2008, Commission staff attended a Stakeholders' Discussion on Health Care Surveillance convened by the American Heart Association in Washington, DC. The meeting included an overview of the essential features of a surveillance system to support the prevention and management of out-of-hospital cardiovascular events (sudden cardiac arrest, stroke, and ST-segment elevation myocardial infarction), and the identification of barriers and opportunities related to policies and appropriations at the state and federal levels.

The Department of Health and Mental Hygiene has begun a process to update the Maryland Perinatal System Standards, which were last revised in October 2004. Commission staff has joined the Department's Perinatal Clinical Advisory Committee in this important endeavor. The most current version of the standards are incorporated by reference in the Commission's State Health Plan for

Facilities and Services: Acute Hospital Inpatient Obstetric Services (COMAR 10.24.12) and State Health Plan for Facilities and Services: Neonatal Intensive Care Services (COMAR 10.24.18).

## *CENTER FOR HEALTH INFORMATION TECHNOLOGY*

### ***Health Information Technology***

Staff completed the draft of the Solutions and Implementation Report, which addresses organizational-level business practices related to privacy and security for health information exchange (HIE). This report represents a lengthy investigation and data analysis by the Solutions and Implementation Workgroup (Workgroup). The Workgroup consisted of representatives from eight Sector Groups that included: consumers, hospitals, long term care, medical laboratory and diagnostic imaging, payers, pharmacies, physicians, and purchasers. Workgroup participants developed guiding principles to exchange patient information electronically, and evaluated current privacy and security practice barriers to HIE. The Workgroup also evaluated the impact of these barriers on the guiding principles and proposed implementation activities for the development of HIE in Maryland. Select Workgroup participants will review the initial draft in May.

Staff continued to participate in the weekly teleconferences of the Certification Commission for Health Information Technology (CCHIT) Network Workgroup (Workgroup). Last month, the Workgroup reviewed the results of a second industry wide CCHIT survey of HIEs on the proposed network certification criteria and test scripts, and an assessment on the level of interest in CCHIT network certification. A preliminary review of the responses suggests that only a limited number of HIEs are ready to participate in a network certification program. The Workgroup also anticipates that it will need to further modify the test scripts following additional testing in May. CCHIT is considering the impact of a delay to the anticipated October 2008 implementation period. The network certification program under development by CCHIT focuses on the technology infrastructure of networks that exchange clinical data.

The Maryland Hospital Association (MHA) Transaction Workgroup (Workgroup) Request for Solution (RFS) proposal to develop the Maryland Transaction Data Interchange Network (network) was released in April. The Workgroup decided to develop a proposal to assess opportunities for a consortium of hospitals to participate in a bulk services agreement or to build a network. Hospitals participating in the Workgroup developed the RFS in an effort to reduce the costs of administrative health care transactions and expand the use of electronic claims status and eligibility transactions. MHA sponsored a bidder's conference in April and approximately 15 vendors participated in the conference. Responses to the RFS are due to the MHA on May 9th. The MHA will evaluate and score the RFS responses and provide that information to the hospitals. The hospitals will then decide on next steps.

Staff continued to work with hospital CIOs on the development of a survey that reports on hospital adoption, implementation, and planning for health information technology (HIT). Survey questions were developed using feedback from hospital CIOs as well as from other HIT surveys. Several questions contained in the survey will allow for national comparison. Over the last month, staff made revisions to the survey based on additional comments it received from several hospital CIOs. The goal is to measure adoption and implementation of HIT in Maryland hospitals as part of the Commission's annual Center for Hospital Services Hospital Quality Survey. Staff plans to solicit additional comments from hospital CIOs in May and pilot the survey in June. Data collected from the survey will be evaluated and reported in an information brief at the end of summer.

Staff is working with the Erickson Foundation to develop a physician electronic health record (EHR) adoption survey. MHCC and the Erickson Foundation have partnered to develop a survey for assessing physician adoption of EHRs in the state. Last month, staff identified a preliminary list of questions for comments by physician practices that have agreed to support the development of the survey. Over the next month, these practices will provide feedback to MHCC on the survey. Staff anticipates finalizing the survey in June. Information obtained from the survey can be used for national comparison and in developing programs to expand EHR adoption in Maryland. The Erickson Foundation will provide the resources to administer the survey.

MHCC is collaborating with the Maryland State Medical Society (MedChi) and the Medical Society of the District of Columbia to submit an application to the Centers for Medicare & Medicaid Services (CMS) for participation in a five-year EHR Demonstration Project. The demonstration project is designed to show that widespread adoption and use of EHRs will reduce medical errors and improve the quality of care. Applicants selected to participate in the demonstration project will be asked to assist CMS in the identification and recruitment of approximately 200 small primary care physician practices. About one half of the physician practices that participate in the demonstration project are eligible to receive a modest incentive payment for adopting EHRs. The remaining physician practices will participate in a control group and be eligible to receive a small incentive payment for completing an Office Systems Survey each year. Staff plans to submit the application to CMS in advance of the May 13th due date.

## ***Health Information Exchange***

Staff presented the MHCC Request for Application (RFA) funding recommendation for *A Citizen Centric Health Information Exchange for Maryland* to the HSCRC at their April Commission meeting. The presentation included an overview of two models recommended for funding by the MHCC: the Chesapeake Regional Information System for our Patients, and the Montgomery County HIE Collaborative. The HSCRC will take final action on the MHCC recommendations at their May Commission meeting. The RFA represents the first phase of a two-phase initiative to build a statewide HIE. The first phase is scheduled for completion in approximately nine months; the second phase of this initiative will incorporate the best features from the planning proposals to build a statewide HIE that will enable the exchange of patient information across health care sectors.

Staff participated in a four day working session of the Health Information Security & Privacy Collaboration (HISPC) Adoption of Standards Collaborative Workgroup (Workgroup). The goal of the HISPC Workgroup is to develop the *National Health Bridge (NHB): Basic Policy Requirements for Authentication and Audit* that supports cross network HIE for the purpose of treatment for individuals and populations as well as an implementation plan that can be used by participating states to guide the adoption of the NHB. Research Triangle Institute (RTI International), a national consulting organization under contract with the Office of the National Coordinator (ONC), has subcontracted with MHCC and seven other states to complete this project.

The Workgroup will identify basic policy requirements that authenticate and audit individuals who access personal health summaries for benefit and treatment information, and can be used to support the efforts in developing technical standards for authentication and audit by the Healthcare Information Technology Standards Panel (HITSP) and the National Health Information Network (NHIN II). MHCC will represent Maryland in this effort, and has released a Bid Board Notice for a contractor to assist the MHCC with facilitation of stakeholder workgroups, development of policy testing protocols, documentation of policy test results, and completion of monthly reports for RTI International. Staff will focus on validating a set of basic policy requirements for authentication and audit developed by several modeling states in the

Workgroup. Staff plans to invite participates from service area health information exchanges (SAHIEs) around the state to take part in validating policy from the modeling states.

Staff continues planning efforts to bring together representatives from SAHIEs to identify a policy framework that will be incorporated in a *SAHIE Planning Guide* (Guide). Staff expects the Guide will help spur uniform adoption of policies and practices within the state that will facilitate the exchange of patient information in a statewide HIE. Last month, staff identified a contractor to facilitate a series of workgroup discussions on an acceptable range of variation in policy development regarding business standards, practices, and privacy and security for communities sharing electronic health information. The workgroup will consist of hospital CIOs and other select stakeholders. The contractor will assist MHCC in developing a framework of best practices for communities engaged in or planning to exchange electronic health information. MHCC anticipates release of the Guide in the fall; an initial meeting of the workgroup is tentatively scheduled in June.

## ***Electronic Health Networks & Electronic Data Interchange***

Staff reviewed GHN On-Line's application for MHCC Electronic Health Network (EHN) candidacy status, and participated in a teleconference call with the network to address staff questions regarding their candidacy application. Presently, 32 networks are MHCC certified and 3 are in candidacy status; MHCC certification is for a two-year period. Staff provided support to the Electronic Network Accreditation Commission (EHNAC) in identifying privacy and security policies for discussion by an industry workgroup that will explore policy accreditation for networks exchanging clinical data. Staff also participated in a meeting of the EHNAC administrative transaction criteria committee to evaluate existing EHNAC criteria and recommend new criteria to reflect changes in technology, regulation, and the marketplace.

The 2007 Dental EDI Review (Review) has been completed and planned for release in May. The Review reports on 2006 dental transactions submitted by 39 private payers, Medicaid, and the seven Medicaid Managed Care Organizations. It also provides an overview of dental EDI activity and trends in the state. Staff provided support to several payers in regards to submitting their 2007 administrative transaction census data. This year, payers will submit their data through a web-based EDI application, which is currently in the final stages of testing. The web-based EDI application will be available to the 42 government and private payers notified to submit their 2008 EDI Progress Report on June 1st. Payers must complete the EDI data submission by June 30th, in accordance with COMAR 10.25.09, *Requirements for Payers to Designate Electronic Health Networks*.

## ***National Networking***

Staff participated in the second of three public meetings regarding the progress in developing a successor to the American Health Information Community (AHIC). Four planning groups have been convened to design key elements of the successor organization, called AHIC 2.0. Updates on the work of the Governance, Membership, and Sustainability Planning groups were presented, including their progress in selecting stakeholder volunteers to participate on the groups. These three groups, as well as the Transition Planning Group, will meet and complete their designs for the AHIC 2.0 by the end of May. It is expected that AHIC 2.0 will become fully operational by December 2008. Staff also participated in the monthly AHIC meeting. The meeting included a presentation on use case development and updates from four of the AHIC workgroups, including the Joint Consumer Empowerment-EHR-Personalized Healthcare-Population Health-Quality Workgroup, the Consumer Empowerment Workgroup, and the Confidentiality, Privacy & Security Workgroup.

Staff participated in a Maryland HIMSS Chapter meeting titled The Electronic Health Record; We Have the Data, Now What? The meeting included a presentation on how organizations that have adopted EHRs are using that information for quality and safety improvement and reduction of risk. Staff also participated in a meeting of the HIMSS PHR Committee for Clinician Outreach Task Force, which discussed distribution of a survey to 1,200 clinicians to determine their current level of EHR and PHR adoption, and the barriers to adopting such technology. The survey is expected to begin in June, and be completed with results made available in the fall of 2008.